§ 40.105 Inability to provide an adequate amount of breath or saliva.

(a) If an employee is unable to provide sufficient breath to complete a test on a non-evidential breath testing device, the procedures of § 40.69 apply.

(b) If an employee is unable to provide sufficient saliva to complete a test on a saliva screening device (e.g., the employee does not provide sufficient saliva to activate the device), the STT, as provided in § 40.101 of this part, shall conduct a new test using a new device. If the employee refuses to complete the new test, the STT shall terminate testing and immediately inform the employer. This constitutes a refusal to test.

(c) If the new test is completed, but there is an insufficient amount of saliva to activate the device, STT shall immediately inform the employer, which shall immediately cause an alcohol test to be administered to the employee using an EBT.

§ 40.107 Invalid tests.

An alcohol test using a non-evidential screening device shall be invalid under the following circumstances:

(a) With respect to a test conducted on a saliva device—

(1) The result is read before two minutes or after 15 minutes from the time the swab is inserted into the device;

(2) The device does not activate;

(3) The device is used for a test after the expiration date printed on its package; or

(4) The STT fails to note in the remarks section of the form that the screening test was conducted using a saliva device;

(b) With respect to a test conducted on any non-evidential alcohol testing device, the STT has failed to note on the remarks section of the form that the employee has failed or refused to sign the form following the recording on the form of the test result.

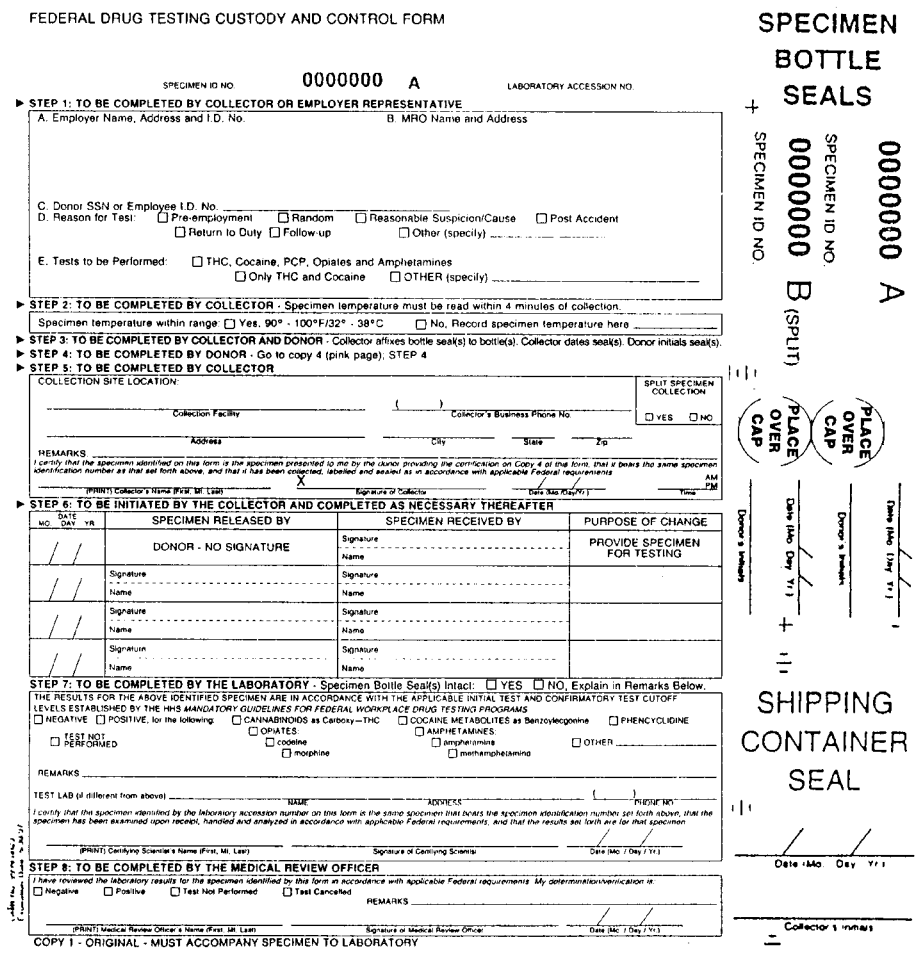
§ 40.109 Availability and disclosure of alcohol testing information about individual employees.

The provisions of § 40.81 apply to records of non-evidential alcohol screening tests.

§ 40.111 Maintenance and disclosure of records concerning non-evidential testing devices and STTs.

Records concerning STTs and non-evidential testing devices shall be maintained and disclosed following the same requirements applicable to BATs and EBTs under § 40.81 of this part.

APPENDIX A TO PART 40—FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000000 A LABORATORY ACCESSION NO.

▶ STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines ☐ Only THC and Cocaine ☐ OTHER (specify)

▶ STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here

▶ STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

▶ STEP 4: TO BE COMPLETED BY DONOR - Go to copy 4 (pink page), STEP 4

▶ STEP 5: TO BE COMPLETED BY COLLECTOR

COLLECTION SITE LOCATION

Collection Facility ( ) Collector's Business Phone No. SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements

(PRINT) Collector's Name (First, MI, Last) X Signature of Collector Date (Mo./Day/Yr.) Time AM PM

▶ STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature / Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature / Name	Signature / Name	
/ /	Signature / Name	Signature / Name	
/ /	Signature / Name	Signature / Name	

STEP 7: TO BE COMPLETED BY THE LABORATORY - Specimen Bottle Seal(s) Intact: ☐ YES ☐ NO, Explain in Remarks Below.

THE RESULTS FOR THE ABOVE IDENTIFIED SPECIMEN ARE IN ACCORDANCE WITH THE APPLICABLE INITIAL TEST AND CONFIRMATORY TEST CUTOFF LEVELS ESTABLISHED BY THE HHS *MANDATORY GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS*

☐ NEGATIVE ☐ POSITIVE, for the following: ☐ CANNABINOIDS as Carboxy-THC ☐ COCAINE METABOLITES as Benzoylecgonine ☐ PHENCYCLIDINE ☐ OPIATES: ☐ codeine ☐ morphine ☐ AMPHETAMINES: ☐ amphetamine ☐ methamphetamine ☐ OTHER ☐ TEST NOT PERFORMED

REMARKS

TEST LAB (if different from above) NAME ADDRESS ( ) PHONE NO.

I certify that the specimen identified by the laboratory accession number on this form is the same specimen that bears the specimen identification number set forth above, that the specimen has been examined upon receipt, handled and analyzed in accordance with applicable Federal requirements, and that the results set forth are for that specimen

(PRINT) Certifying Scientist's Name (First, MI, Last) Signature of Certifying Scientist Date (Mo. / Day / Yr.)

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 1 - ORIGINAL - MUST ACCOMPANY SPECIMEN TO LABORATORY

SPECIMEN BOTTLE SEALS

SPECIMEN ID NO. 0000000 A

SPECIMEN ID NO. 0000000 B (SPLIT)

PLACE OVER CAP PLACE OVER CAP

Donor's Initials Date (Mo. Day Yr.) Donor's Initials Date (Mo. Day Yr.)

SHIPPING CONTAINER SEAL

Date (Mo. Day Yr.)

Collector's Initials

Paperwork Reduction Act Notice (as required by 5 CFR 1320.21)

Public reporting burden for this collection of information, including the time for reviewing instructions ,gathering and maintaining the data needed, and completing and reviewing the collection of information is estimated for each respondent to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/laboratory; and 3 minutes/Medical Review Officer. Federal employees may send comments regarding these burden estimates, or any other aspect of this collection of information, including suggestions for reducing the burden, to Public Health Service Reports Clearance Officer, Attn: PRA, Hubert H. Humphrey Building, Rm 721-B, 200 Independence Ave. S.W., Washington, D.C. 20201. Individuals from the private sector may send comments/suggestions to: Department of Transportation, Drug Enforcement and Program Compliance, Rm 9404, 400 Seventh St. S.W., Washington, D.C. 20590. In addition, copies of all comments/suggestions may be sent to: Office of Management and Budget, Paperwork Reduction Project, Rm 3001, 725 Seventeenth St. N.W., Washington, D.C. 20503.

Back of Copy 1, 2, 3, 4, and 6.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines ☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: TO BE COMPLETED BY DONOR - Go to copy 4 (pink page); STEP 4

STEP 5: TO BE COMPLETED BY COLLECTOR

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) AM PM Time

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

STEP 7: TO BE COMPLETED BY THE LABORATORY - Specimen Bottle Seal(s) Intact: ☐ YES ☐ NO, Explain in Remarks Below.

THE RESULTS FOR THE ABOVE IDENTIFIED SPECIMEN ARE IN ACCORDANCE WITH THE APPLICABLE INITIAL TEST AND CONFIRMATORY TEST CUTOFF LEVELS ESTABLISHED BY THE HHS *MANDATORY GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS*

☐ NEGATIVE ☐ POSITIVE, for the following: ☐ CANNABINOIDS as Carboxy—THC ☐ COCAINE METABOLITES as Benzoylecgonine ☐ PHENCYCLIDINE ☐ OPIATES: ☐ codeine ☐ morphine ☐ AMPHETAMINES: ☐ amphetamine ☐ methamphetamine ☐ OTHER _____ ☐ TEST NOT PERFORMED

REMARKS _____

TEST LAB (if different from above) _____ NAME ADDRESS ( ) PHONE NO.

I certify that the specimen identified by the laboratory accession number on this form is the same specimen that bears the specimen identification number set forth above, that the specimen has been examined upon receipt, handled and analyzed in accordance with applicable Federal requirements, and that the results set forth are for that specimen.

(PRINT) Certifying Scientist's Name (First, MI, Last) Signature of Certifying Scientist Date (Mo. / Day / Yr.)

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 2 - 2nd ORIGINAL - MUST ACCOMPANY SPECIMEN TO LABORATORY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. -B LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines ☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: TO BE COMPLETED BY DONOR - Go to copy 4 (pink page); STEP 4

STEP 5: TO BE COMPLETED BY COLLECTOR

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) Time AM PM

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

STEP 7: TO BE COMPLETED BY THE LABORATORY - Specimen Bottle Seal(s) Intact: ☐ YES ☐ NO, Explain in Remarks Below.

THE RESULTS FOR THE ABOVE IDENTIFIED SPECIMEN ARE IN ACCORDANCE WITH THE APPLICABLE PROCEDURES ESTABLISHED BY THE HHS MANDATORY *GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS*

☐ RECONFIRMED for the following: ☐ CANNABINOIDS as Carboxy—THC ☐ COCAINE METABOLITES as Benzoyleogonine ☐ PHENCYCLIDINE
☐ FAILED TO RECONFIRM ☐ OPIATES: ☐ AMPHETAMINES:
☐ TEST NOT PERFORMED ☐ codeine ☐ amphetamine ☐ OTHER _____
☐ morphine ☐ methamphetamine

REMARKS _____

TEST LAB (if different from above) _____ NAME ADDRESS ( ) PHONE NO.

I certify that the specimen identified by the laboratory accession number on this form is the same specimen that bears the specimen identification number set forth above, that the specimen has been examined upon receipt, handled and analyzed in accordance with applicable Federal requirements, and that the results set forth are for that specimen.

(PRINT) Certifying Scientist's Name (First, MI, Last) Signature of Certifying Scientist Date (Mo. / Day / Yr.)

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Reconfirmed ☐ Failed to reconfirm- Both tests cancelled ☐ Test not performed Both tests cancelled REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 3 - SPLIT SPECIMEN MUST ACCOMPANY SPLIT SPECIMEN TO LABORATORY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident
☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines
☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

► **STEP 4: SEE BELOW**

STEP 5: TO BE COMPLETED BY COLLECTOR - RETURN TO COPY 1

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) Time AM PM

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

► **STEP 4: TO BE COMPLETED BY DONOR**

Daytime Phone No. ( ) Evening Phone No ( ) Date of Birth / / Mo. Day Yr.

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence and that the information provided on this form and on the label affixed to each specimen bottle is correct.

(PRINT) Donor's Name (First, MI, Last) X Signature of Donor Date (Mo. / Day / Yr.)

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications as a "memory jogger." THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5).—DO NOT LIST ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 4 - SEND DIRECTLY TO MEDICAL REVIEW OFFICER - DO NOT SEND TO LABORATORY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident
☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines
☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: SEE BELOW

STEP 5: TO BE COMPLETED BY COLLECTOR - RETURN TO COPY 1

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) Time AM PM

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

STEP 4: TO BE COMPLETED BY DONOR

Daytime Phone No. ( ) Evening Phone No. ( ) Date of Birth / / Mo. Day Yr.

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence and that the information provided on this form and on the label affixed to each specimen bottle is correct.

(PRINT) Donor's Name (First, MI, Last) X Signature of Donor Date (Mo. / Day / Yr.)

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications as a "memory jogger." THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5).—DO NOT LIST ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 5 - GIVE TO DONOR DO NOT SEND TO LABORATORY

Privacy Act Statement: (For Federal Employees Only)

Submission of the information on the attached form is voluntary. However, incomplete submission of the information, refusal to provide a urine specimen, or substitution or adulteration of a specimen may result in delay or denial of your application for employment/appointment or may result in removal from the Federal service or other disciplinary action.

The authority for obtaining the urine specimen and identifying information contained herein is Executive Order 12564 ("Drug-Free Federal Workplace"), 5 U.S.C. § 3301 (2), 5 U.S.C. § 7301 and Section 503 of Public Law 100-71, 5 U.S.C. § 7301 note. Under provisions of Executive Order 12564 and 5 U.S.C. 7301, test results may only be disclosed to agency officials on a need-to-know basis. This may include the agency Medical Review Officer, the administrator of the Employee Assistance Program, and a supervisor with authority to take adverse personnel action. This information may also be disclosed to a court where necessary to defend against a challenge to an adverse personnel action.

Submission of your SSN is not required by law and is voluntary. Your refusal to furnish your number will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited, pursuant to Executive Order 9397, for purposes of associating information in agency files relating to you and for purposes of identifying the specimen provided for urinalysis testing for illegal drugs. If you refuse to indicate your SSN, a substitute number or other identifier will be assigned, as required, to process the specimen.

In the event laboratory analysis determines the presence of one or more illegal drugs in the specimen you provide, you will be contacted by an agency Medical Review Officer (MRO). The MRO will determine whether there is a legitimate medical explanation for the drug(s) identified by urinalysis.

Paperwork Reduction Act Notice (as required by 5 CFR 1320.21)

Public reporting burden for this collection of information, including the time for reviewing instructions, gathering and maintaining the data needed, and completing and reviewing the collection of information is estimated for each respondent to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/laboratory; and 3 minutes/Medical Review Officer. Federal employees may send comments regarding these burden estimates, or any other aspect of this collection of information, including suggestions for reducing the burden, to Public Health Service Reports Clearance Officer, Attn: PRA, Hubert H. Humphrey Building, Rm 721-B, 200 Independence Ave. S.W., Washington, D.C. 20201. Individuals from the private sector may send comments/suggestions to: Department of Transportation, Drug Enforcement and Program Compliance, Rm 9404, 400 Seventh St. S.W., Washington, D.C. 20590. In addition, copies of all comments/suggestions may be sent to: Office of Management and Budget, Paperwork Reduction Project, Rm 3001, 725 Seventeenth St. N.W., Washington, D.C. 20503.

Back of Copy 5.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident
☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines
☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: SEE BELOW

STEP 5: TO BE COMPLETED BY COLLECTOR - RETURN TO COPY 1

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) Time AM PM

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature / Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature / Name	Signature / Name	
/ /	Signature / Name	Signature / Name	
/ /	Signature / Name	Signature / Name	

STEP 4: TO BE COMPLETED BY DONOR

Daytime Phone No. [redacted] Evening Phone No. [redacted] Date of Birth ___/___/___ Mo. Day Yr.

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence and that the information provided on this form and on the label affixed to each specimen bottle is correct.

(PRINT) Donor's Name (First, MI, Last) Signature of Donor Date (Mo. / Day / Yr.)

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications as a "memory jogger." THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5).—DO NOT LIST ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 6 COLLECTOR RETAINS DO NOT SEND TO LABORATORY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. LABORATORY ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No. B. MRO Name and Address

C. Donor SSN or Employee I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident
☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

E. Tests to be Performed: ☐ THC, Cocaine, PCP, Opiates and Amphetamines
☐ Only THC and Cocaine ☐ OTHER (specify) _____

STEP 2: TO BE COMPLETED BY COLLECTOR - Specimen temperature must be read within 4 minutes of collection.

Specimen temperature within range: ☐ Yes, 90° - 100°F/32° - 38°C ☐ No, Record specimen temperature here _____

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: SEE BELOW

STEP 5: TO BE COMPLETED BY COLLECTOR - RETURN TO COPY 1

COLLECTION SITE LOCATION:

Collection Facility ( ) Collector's Business Phone No.

SPLIT SPECIMEN COLLECTION ☐ YES ☐ NO

Address City State Zip

REMARKS: _____

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Copy 4 of this form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labelled and sealed as in accordance with applicable Federal requirements.

(PRINT) Collector's Name (First, MI, Last) Signature of Collector Date (Mo./Day/Yr.) Time AM PM

STEP 6: TO BE INITIATED BY THE COLLECTOR AND COMPLETED AS NECESSARY THEREAFTER

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	DONOR - NO SIGNATURE	Signature Name	PROVIDE SPECIMEN FOR TESTING
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

STEP 4: TO BE COMPLETED BY DONOR

Daytime Phone No. Evening Phone No. Date of Birth ___/___/___ Mo. Day Yr.

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence and that the information provided on this form and on the label affixed to each specimen bottle is correct.

(PRINT) Donor's Name (First, MI, Last) Signature of Donor Date (Mo. / Day / Yr.)

Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications as a "memory jogger." THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5).—DO NOT LIST ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 8: TO BE COMPLETED BY THE MEDICAL REVIEW OFFICER

I have reviewed the laboratory results for the specimen identified by this form in accordance with applicable Federal requirements. My determination/verification is:

☐ Negative ☐ Positive ☐ Test Not Performed ☐ Test Cancelled

REMARKS _____

(PRINT) Medical Review Officer's Name (First, MI, Last) Signature of Medical Review Officer Date (Mo. / Day / Yr.)

COPY 7 FORWARD TO EMPLOYER - DO NOT SEND TO LABORATORY

INSTRUCTION FOR COMPLETING DRUG TESTING CUSTODY AND CONTROL FORM

The following instructions are in accordance with procedures established by the Department of Health and Human Services and the Department of Transportation mandatory guidelines for federal and transportation workplace drug testing programs.

NOTE: Use ballpoint pen, press hard, and check all copies for legibility

STEP 1

If the information in STEP 1 has not been completed, collector (not donor) completes STEP 1 (A-E).

NOTE: Donor refusal to provide SSN or Employee I.D. number must be annotated in STEP 5, collector's REMARKS section.

STEP 2.

Upon receiving specimen from donor, check specimen temperature. This must be accomplished within 4 minutes.

Check block marked "Yes" if temperature is within range.

If specimen temperature is not within range, check block marked "No" and record specimen temperature.

STEP 3. FOR SPLIT SPECIMEN COLLECTIONS ONLY

Secure caps on both specimen bottles and affix specimen bottle seal labeled A over the cap and down the sides of the primary specimen (bottle containing at least 30ml of urine).

Affix specimen bottle seal labeled B (split) on the split specimen (bottle containing at least 15ml of urine) in the same manner.

Record date on both specimen bottle seals.

FOR SINGLE SPECIMEN COLLECTION ONLY

Secure cap on specimen bottle (containing at least 30ml of urine) and affix specimen bottle seal labeled A over the cap and down the sides of the specimen bottle.

Record date on specimen bottle seal.

Instruct donor to initial the specimen bottle seal.

STEP 4.

Turn to Copy 4 (pink page), STEP 4.

Instruct donor to complete STEP 4.

Ensure donor provides his/her daytime and evening phone number and date of birth.

Instruct donor to read certification statement. Ensure donor prints his/her name and signs and dates the certification statement.

NOTE: Donor refusal to sign must be annotated in STEP 5, collector's remarks section.

Upon completion, check donor entries, return to Copy 1.

STEP 5.

After returning to Copy 1, go to STEP 5.

Complete the name and address of the facility at which the collection is taking place.

List a business telephone number where collector can be reached.

Place a check in the box indicating whether or not a split specimen was collected.

Record any unusual occurrences concerning the collection (e.g., donor refusal to provide information/sign certification statement, specimen collected under direct observation, suspected adulteration) in the remarks section.

Collector completes collection certification section by printing and signing his/her name, recording the date and time of collection. Be sure to circle A.M. or P.M.

STEP 6. CHAIN OF CUSTODY SECTION

NOTE: Each time the specimen is handled, transferred, or placed into storage prior to being packaged for shipment, every individual must be identified (including a direct observer, if required) and the date and purpose of change recorded. The following instructions pertain to a collection in which the donor provides a specimen directly to the collector who seals, packages, and ships the specimen to the laboratory.

Record date of collection.

In the "Specimen Received By" column, sign and print your name indicating that you have received the specimen from the donor.

The "Purpose of Change" entry in the next column is pre-printed (Provide Specimen for Testing) and explains the transfer of the specimen from the donor to the collector.

On the next line, record the date the specimen was released by you.

Complete the "Specimen Released By" block by signing and printing your name.

If you are preparing the specimen for shipment to the laboratory complete the "Specimen Received By" block by printing the carrier or shipment provider name only. (See Example)

Complete the "Purpose of Change" block explaining the transfer of the specimen from the collector to the carrier or shipment provider (e.g. Ship Specimen to Lab).

DATE MO. DAY YR.	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
8 / 15 / 94	DONOR - NO SIGNATURE	Signature Connie Collector Name Connie Collector	PROVIDE SPECIMEN FOR TESTING
8 / 15 / 94	Signature Connie Collector Name Connie Collector	Signature Name ABC Courier Service	SHIP SPECIMEN TO LAB
/ /	Signature Name	Signature Name	
/ /	Signature Name	Signature Name	

COMPLETING THE COLLECTION PROCESS

Upon completing Step 6, give donor his/her copy, Copy 5, (green page) of the Drug Testing Custody and Control Form.

Donor may leave the collection site at this point.

If a split specimen collection was performed, place both specimen bottles and Copies 1, 2, and 3 of the Drug Testing Custody and Control Form in the shipping container.

If a single collection was performed, place the specimen bottle and Copies 1 and 2 of the Drug Testing Custody and Control Form in the shipping container. Discard Copy 3.

Secure the shipping container. On the shipping container seal, record your initials and the date.

Send Copy 4 (pink page) directly to the Medical Review Officer. Do not send to laboratory.

Retain Copy 6 (yellow page) for your records.

Forward Copy 7 (blue page) to the employer. Do not send to laboratory.

[59 FR 43002, Aug. 19, 1994, as amended at 60 FR 19537, Apr. 19, 1995]

APPENDIX B TO PART 40—THE BREATH ALCOHOL TESTING FORM

U.S. Department of Transportation (DOT) Breath Alcohol Testing Form

[THE INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE BACK OF COPY 3]

▸ **STEP 1: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

A. Employee Name _____
(PRINT) (First, M.I., Last)

B. SSN or Employee ID No. _____

C. Employer Name, Address, & Telephone No. _____

_____

_____ ( )
Telephone Number

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post-accident ☐ Return to Duty ☐ Follow-up

▸ **STEP 2: TO BE COMPLETED BY EMPLOYEE**

I certify that I am about to submit to breath alcohol testing required by U.S. Department of Transportation regulations and that the identifying information provided on this form is true and correct.

_____ Date ___/___/___
Signature of Employee Month Day Year

▸ **STEP 3: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

I certify that I have conducted breath alcohol testing on the above named individual in accordance with the procedures established in the U.S. Department of Transportation regulation, 49 CFR Part 40, that I am qualified to operate the testing devices identified, and that the results are as recorded.

Screening test: Complete **only** if the testing device is not designed to **print** the following.

Test No.	Testing Device Name	Testing Device Serial Number	Time AM PM	Result

Confirmation test: Confirmation test results MUST be affixed to the back of each copy of this form.

Remarks: _____

_____

_____

_____ _____ Date ___/___/___
(PRINT) Breath Alcohol Technician's Name (First, M.I., Last) Signature of Breath Alcohol Technician Month Day Year

▸ **STEP 4: TO BE COMPLETED BY EMPLOYEE**

*I certify that I have submitted to the breath alcohol test the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment if the results are **0.02 or greater**.*

_____ Date ___/___/___
Signature of Employee Month Day Year

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER

OMB No. 2105-0529
Exp. Date: 2/28/97

AFFIX SCREENING TEST RESULTS HERE (IF APPLICABLE) USE TAMPER-EVIDENT TAPE	AFFIX CONFIRMATION TEST RESULTS HERE USE TAMPER-EVIDENT TAPE

PAPERWORK REDUCTION ACT NOTICE (as required by 5 CFR 1320.21)

Public reporting burden for this collection of information is estimated for each respondent to average: 1 minute/employee, 4 minutes/Breath Alcohol Technician. Individuals may send comments regarding these burden estimates, or any other aspect of this collection of information, including suggestions for reducing the burden, to U.S. Department of Transportation, Drug Enforcement and Program Compliance, Room 9404, 400 Seventh St., SW, Washington, D.C. 20590 or Office of Management and Budget, Paperwork Reduction Project, Room 3001, 725 Seventeenth St., NW, Washington, D.C. 20503.

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER

OMB No. 2105-0529
Exp. Date: 2/28/97

U.S. Department of Transportation (DOT)
Breath Alcohol Testing Form

[THE INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE BACK OF COPY 3]

▸ **STEP 1: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

A. Employee Name _____
(PRINT) (First, M.I., Last)

B. SSN or Employee ID No. _____

C. Employer Name, _____
Address, &
Telephone No. _____

_____

_____ ( ) _____
Telephone Number

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post-accident ☐ Return to Duty ☐ Follow-up

▸ **STEP 2: TO BE COMPLETED BY EMPLOYEE**

I certify that I am about to submit to breath alcohol testing required by U.S. Department of Transportation regulations and that the identifying information provided on this form is true and correct.

_____ ___/___/___
Signature of Employee Date Month Day Year

▸ **STEP 3: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

I certify that I have conducted breath alcohol testing on the above named individual in accordance with the procedures established in the U.S. Department of Transportation regulation, 49 CFR Part 40, that I am qualified to operate the testing devices identified, and that the results are as recorded.

Screening test: Complete **only** if the testing device is not designed to **print** the following.

_____ _____ _____ _____ AM PM _____
Test No. Testing Device Name Testing Device Serial Number Time Result

Confirmation test: Confirmation test results **MUST** be affixed to the back of each copy of this form.

Remarks: _____

_____

_____

_____ _____ ___/___/___
(PRINT) Breath Alcohol Technician's Name (First, M.I., Last) Signature of Breath Alcohol Technician Date Month Day Year

▸ **STEP 4: TO BE COMPLETED BY EMPLOYEE**

*I certify that I have submitted to the breath alcohol test the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment if the results are **0.02 or greater.***

_____ ___/___/___
Signature of Employee Date Month Day Year

COPY 2 - EMPLOYEE RETAINS

OMB No. 2105-0529
Exp. Date: 2/28/97

AFFIX SCREENING TEST RESULTS HERE (IF APPLICABLE)	AFFIX CONFIRMATION TEST RESULTS HERE
USE TAMPER-EVIDENT TAPE	USE TAMPER-EVIDENT TAPE

Privacy Act Statement

(applicable in those cases where completed Breath Alcohol Testing Forms are retained in a Federal Privacy Act system of records)

Except for your Social Security Number (SSN), submission of the information on the front side of this form is mandatory. Incomplete submission of the information, failure to provide an adequate breath specimen for testing without a valid medical explanation, engaging in conduct that clearly obstructs the testing process, or failure to sign the certification statements on the front side of this form may result in delay or denial of your application for employment/appointment, your inability to resume performing safety-sensitive duties, removal from a safety-sensitive position, or other disciplinary action.

The authority for obtaining the breath specimen required by the U.S. Department of Transportation is the Omnibus Transportation Employee Testing Act of 1991, Pub. L. 102-143, Title V. The principal purpose for which the information sought is to be used is to ensure that you have submitted to breath alcohol testing and to ensure that you are promptly notified in the event of noncompliance with the U.S. Department of Transportation breath alcohol testing requirements.

Submission of your SSN is not required by law and is voluntary. If you object to the use of your SSN in this form, you will not be denied any right, benefit, or privilege provided by law; a substitute number or other identifier will be assigned.

The information provided in this form may be disclosed, as a routine use, to a Federal, State, or local agency for authorized investigative or enforcement purposes or to a court or an administrative tribunal when the Government or one of its agencies is a party to a judicial proceeding before the court or involved in administrative proceedings before the tribunal.

PAPERWORK REDUCTION ACT NOTICE (as required by 5 CFR 1320.21)

Public reporting burden for this collection of information is estimated for each respondent to average: 1 minute/employee, 4 minutes/Breath Alcohol Technician. Individuals may send comments regarding these burden estimates, or any other aspect of this collection of information, including suggestions for reducing the burden, to U.S. Department of Transportation, Drug Enforcement and Program Compliance, Room 9404, 400 Seventh St., SW, Washington, D.C. 20590 or Office of Management and Budget, Paperwork Reduction Project, Room 3001, 725 Seventeenth St., NW, Washington, D.C. 20503.

COPY 2 - EMPLOYEE RETAINS

OMB No. 2105-0529
Exp. Date: 2/28/97

U.S. Department of Transportation (DOT)
Breath Alcohol Testing Form

[THE INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE BACK OF COPY 3]

▸ **STEP 1: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

A. Employee Name _____
(PRINT) (First, M.I., Last)

B. SSN or Employee ID No. _____

C. Employer Name, Address, & Telephone No. _____

_____

_____ ( ) _____
Telephone Number

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post-accident ☐ Return to Duty ☐ Follow-up

▸ **STEP 2: TO BE COMPLETED BY EMPLOYEE**

I certify that I am about to submit to breath alcohol testing required by U.S. Department of Transportation regulations and that the identifying information provided on this form is true and correct.

_____ Date ___/___/___
Signature of Employee Month Day Year

▸ **STEP 3: TO BE COMPLETED BY BREATH ALCOHOL TECHNICIAN**

I certify that I have conducted breath alcohol testing on the above named individual in accordance with the procedures established in the U.S. Department of Transportation regulation, 49 CFR Part 40, that I am qualified to operate the testing devices identified, and that the results are as recorded.

Screening test: Complete **only** if the testing device is not designed to **print** the following.

Test No.	Testing Device Name	Testing Device Serial Number	Time AM PM	Result

Confirmation test: Confirmation test results **MUST** be affixed to the back of each copy of this form.

Remarks: _____

_____

_____

_____ _____ Date ___/___/___
(PRINT) Breath Alcohol Technician's Name (First, M.I., Last) Signature of Breath Alcohol Technician Month Day Year

▸ **STEP 4: TO BE COMPLETED BY EMPLOYEE**

I certify that I have submitted to the breath alcohol test the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment if the results are 0.02 or greater.

_____ Date ___/___/___
Signature of Employee Month Day Year

COPY 3 - BREATH ALCOHOL TECHNICIAN RETAINS

OMB No. 2105-0529
Exp. Date: 2/28/97

AFFIX SCREENING TEST RESULTS HERE (IF APPLICABLE)	AFFIX CONFIRMATION TEST RESULTS HERE
USE TAMPER-EVIDENT TAPE	USE TAMPER-EVIDENT TAPE

INSTRUCTIONS FOR COMPLETING THE U.S. DEPARTMENT OF TRANSPORTATION BREATH ALCOHOL TESTING FORM

NOTE: Use a ballpoint pen, press hard, and check all copies for legibility.

STEP 1 The Breath Alcohol Technician (BAT) completes the information required in this step. Be sure to print the employee's name and check the box identifying the reason for the test.

NOTE: If the employee refuses to provide SSN or I.D. number, be sure to indicate this in the remarks section in STEP 3. Proceed with STEP 2.

STEP 2 Instruct the employee to read, sign, and date the employee certification statement in STEP 2.

NOTE: If the employee refuses to sign the certification statement, do not proceed with the alcohol test. Contact the designated employer representative.

STEP 3 The Breath Alcohol Technician (BAT) completes the information required in this step. After conducting the alcohol screening test, do the following (as appropriate):

If the breath testing device used in conducting the screening test is not capable of printing the screening test information located on the front of this form (test number, testing device name, testing device serial number, time of test and results), complete this information in the space provided on the front of this form,

NOTE: Be sure to enter the result of the test exactly as it is indicated on the breath testing device, i.e., 0.00, 0.02, 0.04, etc.

OR, If the breath testing device used in conducting the screening test is capable of printing the screening test information located on the front of this form, affix the printed information in the space provided above. Be sure to use tamper-evident tape.

If the results of the screening test are less than 0.02, print, sign your name, and enter today's date in the space provided. Go to STEP 4.

If the results of the screening test are 0.02 or greater, a confirmation test must be administered in accordance with DOT regulations. An EVIDENTIAL BREATH TESTING device that is capable of printing confirmation test information must be used in conducting this test.

After conducting the alcohol confirmation test, affix the printed information in the space provided above. Be sure to use tamper-evident tape.

Print, sign your name, and enter the date in the space provided. Go to STEP 4.

STEP 4 Instruct the employee to read, sign, and date the employee certification statement in STEP 4.

NOTE: If the employee refuses to sign the certification statement in STEP 4, be sure to indicate this in the remarks section in STEP 3.

Forward Copy 1 (white page) to the employer.
Give Copy 2 (green page) to the employee.
Retain Copy 3 (blue page) for BAT records.

PAPERWORK REDUCTION ACT NOTICE (as required by 5 CFR 1320.21)

Public reporting burden for this collection of information is estimated for each respondent to average: 1 minute/employee, 4 minutes/Breath Alcohol Technician. Individuals may send comments regarding these burden estimates, or any other aspect of this collection of information, including suggestions for reducing the burden, to U.S. Department of Transportation, Drug Enforcement and Program Compliance, Room 9404, 400 Seventh St., SW, Washington, D.C. 20590 or Office of Management and Budget, Paperwork Reduction Project, Room 3001, 725 Seventeenth St., NW, Washington, D.C. 20503.

COPY 3 - BREATH ALCOHOL TECHNICIAN RETAINS

OMB No. 2105-0529
Exp. Date: 2/28/97

[59 FR 43013, Aug. 19, 1994]